

LEARNING FROM PAST EXPERIENCES

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Introduction

The goal of this presentation is to examine what we can extrapolate from previous Lessons Learned attempts and suggest possible improvements.



Background

- Modernization project involving risk management & program assurance tasks
- Electrical near-fatality MIB identified 2 similar previous occurrences in the same facility
- Gulfstream III aircraft engine overheating
- Unexpected odor in the EMU



Communication Techniques

- Mr. Griffin's emails contain pointers
- Mr. O'Connor publicizes good reports
- HQ Mishap POC emails mishap highlights to Center POCs



Communication Techniques (cont.)

- JSC Website has a Close Call database
- JSC Hazard Abatement Process on-line
- JSC Sr. Staff Page has mishap report links
- JSC Management Council Briefings



Communication Techniques (cont.)

- Some JSC Directorates have email lists for initial mishap reporting
- JSC Safety Alert
- WSTF has a link to on-site mishap reports on the homepage

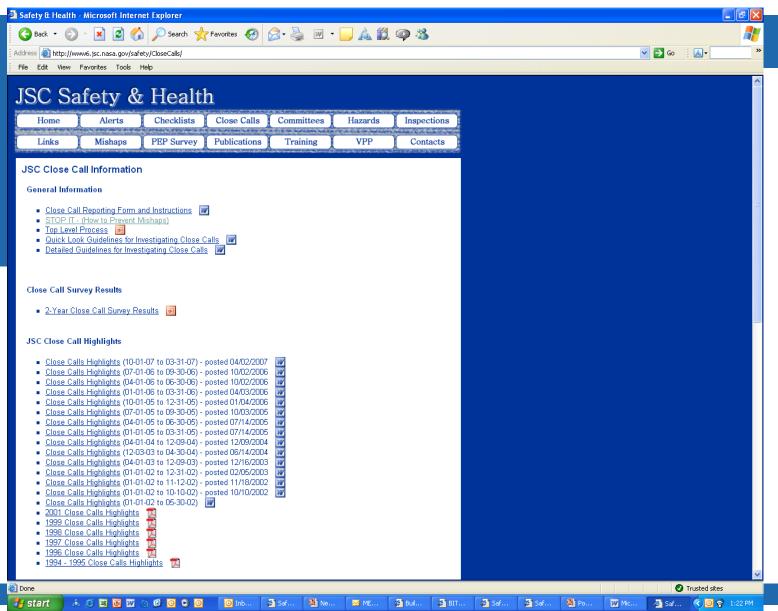


Close Calls

- Nitrogen Asphyxiation
- MIWG MISHAP
- Galileo Moisture Damage

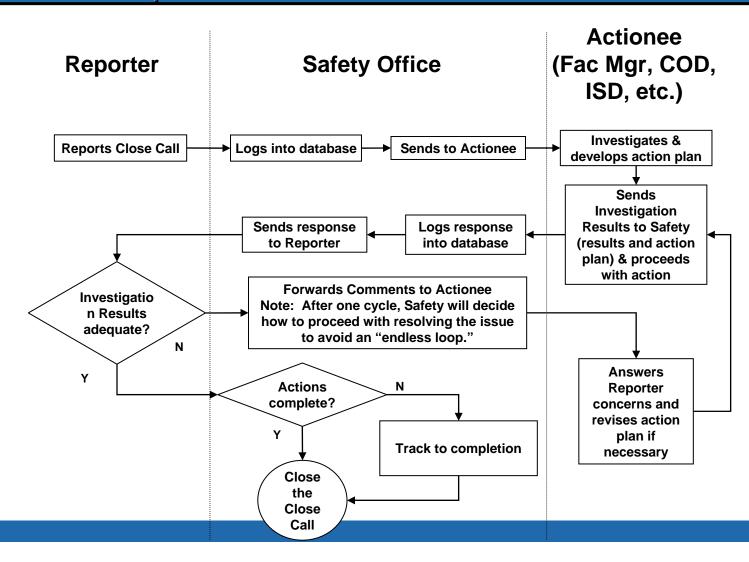


Close Call Web Site





JSC's Top Level Close Call Process Flow





Hazard Abatement Tracking System (HATS)

What is the HATS?

Why do we have a HATS?

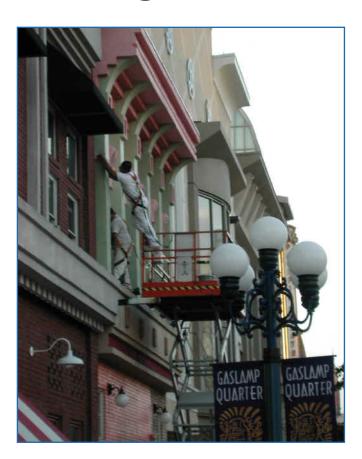
Who maintains the HATS?

The Occupational Safety Team, NS2



Porcelain Press

(What's Wrong with this Picture)





Possible General Improvements

- Verification of flow-down efforts for findings (lateral and down). This should include all communication efforts.
- Is the the LLIS on-line location publicity geared to both to design engineers and facility safety engineers?



Design Improvements

- Is configuration management part of the process?
- How closely do the system safety analysts and the quality control assurance people work?



MIB Improvements

- Looking at possible communication improvements
- Are the same issues that restrict initiating MIBs also a problem with identifying and communicating findings?



Summary

- NASA has a history of repeating mishaps
- Various tools to mitigate risk
- Communication opportunities available to prevent repetitive incidents
- We need to do a better job of protecting NASA people, programs, facilities, and the public from NASA incidents



Summary (cont.)

- Things to consider before and after mishaps
- What have we done to improve our efforts to communicate lessons learned?
- Heighten awareness of the Lessons Learned Information System



Summary (cont.)

 The final analysis of the effectiveness in using Lessons Learned is how diligently we use them